June 1, 2001

Dear Colleague:

With this note we are attaching a draft of the Activity Approval Document (AAD) for the new Center-wide communication activity we plan to award next year. We welcome your comments, questions, additions, and other issues on the new framework. We also would welcome any clarifications.

For your information, the document also includes a glossary of terms relevant to health communication. This too is for comments, clarifications, and additions. The purpose of the glossary is to provide a common terminology for discussion. We are not trying to impose any specific school of thought or definition, merely facilitate dialogue.

Please give us your comments via e-mail (Sratzan@USAID.gov and EFox@USAID.gov) or fax (202 216 3702 and 202 216 3404) by COB June 18.

On June 8 we are hosting a public interested parties meeting on the new framework at George Washington University, School of Public Health and Health Services, Ross hall, Room 117, 2300 I Street, NW (above GWU Foggy Bottom Metro) between 8:30 AM and 12:00. We hope you can join us for a lively give and take on USAID's plans for health communication for the next decade. An RSVP form is attached. Please RSVP by email or fax to Carrie Whitlock at cwhitlock@pal-tech.com, (fax) 202.783.2767.

We look forward to your contribution to this exciting new activity.

Sincerely yours,

Scott Ratzan and Elizabeth Fox
Population, Health, and Nutrition Center
USAID

Interested Parties meeting on
Communication in family planning and health
June 8, 2001
George Washington University

RSVP Form

Name Position

Organization

Address

Fax

Phone

E-mail

Please RSVP by May 31st.

RSVP to:
Carrie Whitlock
cwhitlock@pal-tech.com
PaL-Tech, Inc.
Fax: 202.783.2767
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DRAFT

COMMUNICATION
ACTIVITY AUTHORIZATION DOCUMENT

DRAFT VERSION JUNE 1, 2001

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I. EXECUTIVE SUMMARY

This document authorizes a cluster of PHN sector-wide communication activities. The activities will contribute to the strategic objective – **Employ communication effectively for improving health, stabilizing population, and advancing a health competent society.**

The sector-wide activity will support the communication components of the five strategic objectives of the PHN Center and the PHN strategic objectives of USAID Missions. Communication tools will range from large-scale mass media and social marketing programs to more targeted group and community behavior change interventions, networking and communication for social change, as well as interpersonal communication. Activities will help develop models of communication that address longer term and sustainable normative shifts in behaviors and policies beyond the individual level such as community mobilization, networking, and communication for social change.

The results of this activity will be measurable changes in key behaviors among target populations. Specific behaviors include: increased and continued rates of contraceptive use, improved immunization rates; increased consumption of vitamin A and other micronutrients; increased rates of breastfeeding and of trained attendants at birth; correct bednet use; hand washing and other hygiene behaviors; increased and correct use of DOTS and of antibiotics, especially treatment for ARI. Activities also will address the cluster of behaviors around HIV/AIDS care, prevention, support and treatment with particular focus on reduction of stigma and unsafe sexual practices as well as increased condom use.

This activity will be carried out over ten years. During this period USAID and its contractors will identify and work with in-country implementing partners and institutions with the aim of increasing their capacity and shifting away from USAID's primary reliance on US-based contractors. To accomplish this shift the activity contains a major institution strengthening and training component to increase the ability of countries to carry out communication and behavior change interventions. At the same time it includes increased support to USAID Missions to design and evaluate communication projects.

The total anticipated cost of programs carried out under this activity is based on current expenditures in communication and behavior change at the Global and Mission levels and an expected increase in expenditures, especially in HIV/AIDS and Infectious Diseases. The majority of the activities will be Mission-funded. Global resources will support: research, technical coordination, strengthening institutions and training programs in countries; expertise and assistance to Missions in strategic planning; program design, monitoring and evaluation; global advocacy and policy programs.

II. RATIONALE

USAID has more than 30 years experience in health communication. USAID research and programs have contributed to significant public health successes including applications of communication programs to family planing, the use of oral rehydration solutions for diarrhea, social marketing of contraceptives and other health products, and improved counseling and health worker-patient relations. The behavior changes resulting from these communication interventions together with advances in the public health such as new vaccines and treatment protocols contributed to significant decreases in maternal and child mortality and morbidity.

USAID communication programs have focused mainly on communication at the individual level. Increasingly, however, USAID-supported programs, most notably NGOs, are applying group and community communication techniques. In some instances the community may be the city, town or village. In others the community may be a neighborhood or an extended network of persons of the same ethnic or racial group. Group and community activities focus on longer-term, normative shifts in behaviors among wider populations, for example safer sex, nutrition/food security, or environmental protection.

USAID's experience and research show that targeted individual approaches and participatory community approaches are necessary for successful public health interventions.[1] Research is not conclusive that either approach has better results than the other does; the objectives usually are different.[2] Research does show, however that multiple methods work best.[3] Programs under this activity are expected to use individual and community approaches as well as other, more recent developments such as networking to speed the diffusion of change and innovation.

USAID programs pioneered the use of new technologies in health communication. Radio, television and the newer tools of Internet and CD-ROMs play important roles in increasing reach and reducing the costs of communication in the public health arena. While substantial barriers still prevent major segments of the population from seeking or using new technologies, the new media, characterized by interactivity, can provide proactive, individualized, and personalized information to the public, high-risk persons, patients, policymakers and providers. The Science Panel on Interactive Communication and Health concluded that few other health-related interventions have the potential of interactive health communication to simultaneously improve health outcomes, decrease health costs, and enhance consumer satisfaction.[4] Under this activity USAID will continue to pioneer the effective application of information technology to achieve public health objectives. In this effort, newer communication technologies will join older,

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[1] Scott Ratzan, "Global Population, Health and Nutrition Communication: A Review of the Literature," presentation at USAID Communication Stakeholders Meeting, Washington, DC, 14 December 2000.
[2] Nancy Morris, "Bridging the Gap: An Examination of Diffusion and Participatory Approaches in Development Communication" paper presented at USAID Communication Stakeholders Meeting, Washington, DC, 14 December 2000.
[3] Thomas Backer and Everett Rogers, Organizational Aspects of Health Communication Campaigns: What Works? (Newbury Park, CA: Sage, 1993).
[4] Thomas Eng and David Gustafson, Science Panel on Interactive Communication and Health. *Wired for Health and Well-Being: the Emergence of Interactive Health Communication.* (Washington, DC: US Department of Health and Human Services, US Government Printing Office, 1999).

proven strategies such as mass media, interpersonal communication and targeted print communication.

USAID has learned that communication works best when it is a part of a larger public health initiative.[5] Communication can influence the public agenda, advocate for policies and programs, promote positive changes in the social, economic and physical environment, stimulate debate and dialogue for health as a priority, and encourage social norms that benefit health and quality of life. Communication, however, cannot deliver health services. For this reason communication programs under this activity will be closely coordinated with programs to improve quality and access to services, strengthen institutions, and formulate effective policies for reproductive, maternal, child health, nutrition, HIV/AIDS and infectious diseases.

USAID has experimented with several ways of integrating communication within PHN programs. For more than twenty years the Office of Population (POP) has supported contraceptive social marketing, a large stand-alone communication activity (Population Communication Services), and smaller communication activities within other reproductive health projects. The Office of Health and Nutrition (HN), on the other hand, moved back and forth between supporting stand-alone communication projects, albeit on a smaller scale than POP, and integrating communication within its flagship projects for maternal and child health and nutrition. Currently almost all HN flagships and specialized projects (BASICS II, MOST, MNH, EHP, FANta, Linkages) have some communication activities. In addition the CHANGE Project develops new tools and approaches for behavior change, including communication. The HIV/AIDS Division has placed behavior change, social marketing, and communication activities in a variety of its projects (AIDSMark, Alliance and IMPACT) but has no stand-alone communication activity.

Integrated models and stand-alone organizations for managing communication projects each present challenges. Evaluations of the latest round of HN flagships (BASICS, EHP, OMNI) identified weaknesses in the integrated design, limiting the effectiveness of implementing communication activities and especially of taking these activities to scale.[6] The recent evaluation of the stand-alone POP communication activity suggested improved coordination is necessary between cooperating agencies (CAs) in the PHN Center.[7] In conclusion, what integration gains in technical coordination it can lose in focus, innovation and ability to go to scale. The opposite often holds true for stand-alone communication projects that can go to scale but lack technical coordination with other CAs focusing on health services and delivery.

In setting the stage for the design of this AAD, USAID convened a roundtable discussion with field representatives, academics and communication practitioners in 1998 to explore and develop

[5] Dina Towbin, "A One-Day Consultation Meeting on Communication in the Population, Health and Nutrition Sector for USAID Staff and External USAID Partners," report from meeting, Washington DC, 14 December 2000.
[6] Interim Evaluation of the BASICS Project (Washington DC: TvT Associates, Inc., 1997);
Interim Evaluation of the Environmental Health Project (EHP) (Washington, DC: TvT Associates, Inc., 1997); "Behavioral Dimensions of Maternal Health & Survival," summary of a consultative forum co-sponsored by MotherCare, the CHANGE Project, and the World Health Organization, (no date).
[7] Evaluation of the Population Communication Services (PCS) Project, 1995-2000 (Washington DC: LTG Associates, Inc., 2001).p.37.

quality standards for health and development communication. The standards were to be used to assess the potential effectiveness and efficiency of health and development communication interventions. The group agreed that a quality health communication program: 1) is evidence-based, 2) includes and analyzes trend data, 3) focuses on promoting informed dialogue and choice, 4) effectively 'frames' an issue[s], 5) is ethical and transparent, 6) contains partnerships, 7) promotes local "ownership", 8) has a structured planning framework, 9) includes substantial resources for evaluation, and 10) works toward sustainability. [8] Evaluation findings and recommendations of USAID projects have supported the importance of these components.

The increasing complexity of health communication, including new definitions of health, evolution of new media and the needs of diverse audiences demands broad, interdisciplinary, multi-sectoral approaches. A recent Institute of Medicine report, *Bridging Disciplines in the Brain: Behavioral and Clinical Sciences*, observes, "Solutions to existing and future health problems will likely require drawing on a variety of disciplines and approaches in which interdisciplinary efforts characterize not only the cutting edge of research but also the utilization of knowledge."[9] Likewise the PCS evaluation suggests the need to apply more recent and innovative communication theory as well as to strengthen the links between outreach activities and community-based support groups to ensure sustainable impact.[10]

Better planning and design frameworks and expertise are needed to manage these complex, interdisciplinary health communication interventions. Experience suggests the integration of communication at the strategic framework and planning level of the Missions as the best way to maximize the successful use and impact of communication interventions. An independent survey of USAID PHN officers managing communication programs, however, revealed little formal training and few resources available for the design and management of communication activities in the field.[11] In response to these and other findings, the new communication AAD will foster broad, interdisciplinary approaches to health communication, and support their design, implementation, evaluation and management.

Partly as a result of USAID's significant investment in the field, communication has become a mature discipline in the United States, containing tried and true theories, interventions, processes, competencies and techniques.[12] Thirty years of investment in the field has produced many successes in terms of client and consumer understanding and use of contraceptives, ORT; hand and food washing; condoms to prevent HIV/AIDS and STDs as well as improved counseling from FP/RH providers. One area, however, where more work needs to done is building the capacity of local communities and institutions. A recent evaluation of USAID's micronutrient portfolio found that although many projects identify [communication] capacity building as part of their goals and workplan, it often gets lower priority status as the need for

[8] More details on each of the quality standards is available at www.comminit.com/review_qualitystandards.html.
[9] Terry Pellmar and Leon Eisenberg, (eds.) "Bridging Disciplines in the Brain, Behavioral and Clinical Sciences," (Washington DC: Institute of Medicine, National Academy Press, 2000)p. 1.
[10] PCS Evaluation, 2001, p. 10.
[11] Susan Mach, "Voices from the Field: Communication for Development," paper prepared for the Joint Rockefeller Foundation/USIAD Conference *Communication for Development*, Bellagio, Italy, October 2000.
[12] Everett Rogers, "The Field of Health Communication Study Today: An Up-to Date Report," *Journal of Health Communication: International Perspective* 1: 1 (1996).

"getting the work done" takes precedence.[13] More attention must be given to appropriate external technical assistance and partnering with universities, training institutions, private sector media and NGOs that can train professionals and carry out programs in a sustainable manner.

The Communication AAD addresses the following issues described above by:

1. Using both individual and community approaches as well as other, more recent developments such as networking and communication for social change to improve the impact of communication activities and facilitate exchange and innovation.
2. Coordinating communication activities with programs to improve quality and access to services, strengthen institutions, and formulate effective policies.
3. Fostering broad, interdisciplinary approaches to health communication and supporting the design and management processes necessary to make them successful.
4. Increasing appropriate external technical assistance and partnering with universities, training institutions, private sector media and NGOs to build sustainable institutions for health communication in the developing countries.

The need for increased integration of individual and community-level communication activities will be met with a large program to implement at-scale communication and social marketing programs using state-of-the-art mass and interpersonal media as well as participatory and community-led interventions. This communication "agency" will respond to global and field demands for national and regional communication strategies, campaigns and programs. To carry out this mandate more effectively and build capacity in countries, the agency will work with a wide range of local and national media and talents, notably commercial and community media and advertising and research firms in the south.

The need to coordinate communication activities with service delivery, policy, research and other areas in the USAID portfolio and foster broad, interdisciplinary approaches will be met with an increased G/PHN in-house capacity to design, evaluate and manage communication programs. This in-house capacity will ensure that the latest technical findings in the areas of family planning and reproductive health, child survival and maternal mortality, and HIV/AIDS and Infectious Diseases, are available to and used by the communication program as well as other cooperating agencies implementing communication programs. Additionally, select USAID bilaterally-funded activities will be identified and analyzed in IR. 3 to ensure innovations and best practices are shared along with lessons learned and potential barriers to success.

Over the ten years of this activity, USAID plans to address the need for sound institutional growth in health communication in developing countries by initially partnering and eventually devolving health communication to appropriate in-country institutions. The awards under this AAD will contain specific requirements and measures to insure this "devolution" to in-country institutions. A regional or national consortium of public health and communication schools and

[13] Review of USAID's Micronutrient Portfolio, (Washington DC: HTS, 1997) p. 51.

subsequent networks of health communicators, for example, could fill the need for human resources while providing research and programmatic implementation capacity. The training component under this communication activity will work closely with other donors and multilateral organizations including WHO, PAHO, and the Rockefeller and Bill and Melinda Gates Foundations to achieve these leadership goals. A procurement under this activity will help develop templates, core curriculum, South-South support and regional coordination, working closely with Mission and other programs already addressing this need.[14]

Finally, the activities in the SO to "employ communication effectively for improving health and stabilizing population" will be ongoing. "Advancing a health competent society" is a conceptual rubric that assists in sustainability of health communication interventions. The devolution of activities amongst individuals, community, governmental and related organizations in country is a goal of health communication. Ideally, a health competent society is composed of active individuals who are health literate, a supportive environment for healthy public policy (sound civil society), and a system with adequate capacity (human and economic) to deliver preventive and curative health services.

III AAD STRATEGIC FRAMEWORK

This AAD seeks to integrate over 30 years of USAID experience in health communication with the needs of the field in the 21st Century. The activity reflects advances in theory and in evidence-based practices of health and communication from the public and private sectors alike along with the latest recommendations in the field of public health.

> "Rather than focusing interventions on a single or limited number of health determinants, interventions on social and behavioral factors should link multiple levels of influence (i.e. individual, interpersonal, institutional, and policy levels)."[15]

A Center-wide activity, the Communication AAD is a cluster of programs within the overall Agency strategic goal of "World Population Stabilized and Human Health Protected." Communication is present across a wide range of PHN priorities – improved preventive, acute and chronic care, supportive social and physical environments, increased education and income, reduced vulnerability/risk factors, and improved health system performance and quality. The activity contributes specifically to G/PHN's five strategic objectives

SSO 1*: Increased use by women and men of voluntary practices that contribute to reduced fertility;*
SSO 2: *Increased use of key maternal health and nutrition interventions;*
SSO 3*: Increased use of key child health and nutrition interventions;*

[14] USAID/PERU Strategic Plan 2002-2006, 15 December 2000.
[15] Institute of Medicine, Promoting Health: Intervention Strategies from Social and Behavioral Research. Recommendation 2. Brian Smedley and S.Leonard Syme (eds) (Washington DC: National Academy Press, 2000) p.9.

SSO 4: *Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic* and
SSO 5: *Increased use of effective interventions to reduce the threat of infectious disease of major public health importance.*

The Strategic Objective for this Communication AAD is to **employ communication effectively for improving health, stabilizing population, and advancing a health competent society.** Programs under the Communication AAD will achieve the following three intermediate results:

IR1 Effective communication programs implemented to change key behaviors related to family planning/reproductive health (FP/RH), maternal and child health and nutrition, HIV/AIDS, and infectious diseases

IR 2 Country-level leadership (and capacity) to implement communication programs strengthened

IR 3 Knowledge, best practices and policies for health and population identified, published, disseminated and utilized

Programs under this AAD will address the specific target populations and key behaviors of the five PHN SOs. In addition, the AAD will support a common agenda of research, innovation, design, evaluation and capacity building. The Communication AAD is not G/PHN's only activity using communication. Other projects supported by the PHN Center will continue to have communication capabilities. The role of the Communication AAD will be to spearhead the Center-wide roles of strategic planning, full-scale program implementation, training and capacity building in communication.

The "centered" nature of this AAD will enhance a number of interrelationships of results and activities that may include:

- Integrating HIV/STI and family planning efforts;
- Building linkages between health communication activities and service delivery and mobilizing and leveraging funds for cross-sectoral activities from other sectors and donors (e.g. democracy and governance, disaster relief);
- Promoting sustainability by creating an environment for in-country institutions to develop networks to enhance diffusion and replication of successful interventions;
- Developing an enabling environment for health communication activities among leading organizations in the field.

IV. RESULTS, ACTIVITIES AND MONITORING

The Communication AAD has three IR's. Results, activities and monitoring under each IR and their sub-IR's are described below.

IR 1 Effective communication programs implemented to change key behaviors related to the prevention and care of family planning/reproductive health (FP/RH), maternal and child health and nutrition, HIV/AIDS, and infectious disease

- IR 1.1 Improved capacity for strategic planning, program design, and monitoring and evaluation of communication programs
- IR 1.2 Effective, evidence-based communication programs implemented at scale
- IR 1.3 Effective integration of communication within wider public health programs
- IR. 1.4 Qualitative and quantitative formative, operations, and summative research conducted for ideal communication interventions

IR 1. Improved capacity for strategic planning, program design, and monitoring and evaluation of communication programs.

The improved capacity in IR1 is both at the institutional, system and individual level. This PHN Center-wide activity may develop evidence-based templates for communication approaches and tools as a USAID brand for effective programmatic impact. For example, PHN Center cooperating agencies could be involved in developing, refining, disseminating and applying the state-of-the-art USAID communication approaches and tools as an extension of the USAID reach/brand. Branded tools are likely to be more relevant and useful to end users because of their systematic research components and multi-disciplinary approaches, combining the expertise of CAs with specialized contextual expertise in areas such as stigma for certain diseases (e.g. HIV/AIDS, TB, etc.) or in areas of reproductive/maternal health.

Additionally, USAID requires an in-house multi-disciplinary technical capacity to manage its growing portfolio of communication activities more effectively. The need for an increased strategic planning capability for communication programs was identified in the process of designing this AAD by G/PHN personnel and PHN officers and Foreign Service Nationals (FSNs) in Missions.[16] Recognizing this need, the PHN Center has hired communication specialists to work on some aspects of communication, namely dissemination and advocacy programs. Missions, however, rarely are able to hire or access this type of expertise. This AAD includes mechanisms for USAID to develop this capacity at the headquarters and Mission levels. (See Management section for further description.)

USAID Missions' need for increased knowledge and skills for the design and management of communication activities will be met by the development and dissemination of programmatic

[16] PCS Evaluation, 2001; Mach, 2000; Survey of USAID PHN Field Officers, November 2000.

planning, implementation and evaluation tools.[17] This activity also could provide in-service training at Mission retreats and regional PHN State-of-the-Art (SOTA) workshops on areas such as the integration of new (e.g. Internet) and old (e.g. telephone) communication technologies. Regional or country workshops could involve a cross-section of staff from Missions and USAID partners related to a specific activity. In Missions where communication has a visible and active role in the portfolio, actions under this sub IR could provide support for strategic communication planning, monitoring, and in-country coordination.

The results of sub-IR 1.1 will be improved design and implementation of more cost-effective communication programs in USAID Missions and partners. These results will be monitored against a series of benchmarks including: development of planning models, cost-effectiveness models, standardized tools, and application of integrated strategic frameworks for communication programs.

IR 1.2 Effective, evidence-based communication programs implemented at scale.

This sub-IR currently represents the main area of operation of the communication project housed in the POP Office. The HN Office, on the other hand, lacks this large-scale implementation capability, and Missions often depend on the POP CA for field activities or do not conduct at-scale communication activities at all.[18] The purpose of this IR is to set up a broad-based communication "agency" with the technical capacity to carry out large-scale programs across the PHN Center and USAID Missions. The agency will have expertise in or access to the appropriate technical capacity in the relevant fields of public health as well as to the in-country implementation agencies (media, research, and creative talent). Over the ten years of the life of this AAD the locus of this communication agency will shift and gradually devolve to and be absorbed by the growing institutional capabilities to carry out communication programs in the developing countries (IR2).

Innovative and science-based communication strategies that will be employed under this sub-IR include media and policy advocacy, social marketing, public relations, negotiation, mass-media campaigns, interpersonal communication, entertainment-education, community mobilization, and other participatory approaches. Programs will apply the over arching principles of strategic communication and may include a balance between campaign-type programs and new approaches. A recent Institute of Medicine (IOM) study on promoting health, for example, advised that efforts to develop the next generation of prevention interventions must focus on building relationships with communities and develop interventions that derive from the communities' assessments of their needs and priorities.[19] At the same time, the BASICS evaluation cautioned USAID not to reject proven mass-media models in favor of more

[17] The CDC has developed their "brand"/model of strategic communication with a CD-ROM training tool called CDCynergy. All Centers and contractors must follow the model/template when implementing communication programs.
[18] Survey of USAID PHN Field Officers, November 2000.
[19] IOM, Recommendation 18, 2000, p.29.

experimental community participation models, but to use both models in a complementary fashion for improved efficacy.[20]

Another strategic area of communication under this sub-IR will be the use of audience segmentation, a hallmark of social marketing. Successes in communication have emphasized population segmentation,[21] recognizing the need to develop differentiated strategies for various sub-groups in regions and settings. Epidemiological, psychographic, demographic and sociometric variables offer a multitude of opportunities for segmentation, all of which have an evidence base for success.[22] Reaching an illiterate population in South Asia and a similar educated cohort in Eastern Europe, for example, requires different approaches. Effective communication will test and support appropriate approaches for reaching audiences of different age groups, gender identification, marriage status, education level, refugee status, health behaviors/norms, culture, and the socially marginalized, all of whom are at special risk for a multitude of health issues. Such evidence-based, multi-disciplinary strategies could advance individual health literacy thereby contributing to the outcome of a health competent society.[23]

IR 1.3 Effective integration of communication within wider public health programs.

This AAD mainly will addresses the key behaviors identified within the five SO's at the individual, community and policy levels. Ideally, however, interventions will help individuals develop the general cognitive and social skills to promote their own health and that of their families, navigate the health care system, and understand the language of health care providers. The result of sub-IR 1.3 is a more supportive environment for health. This implies that people more effectively participate in decisions about their health, working with community groups, public-private partnerships, and other interested parties. With the aid of new information technologies, communication can facilitate future scenarios where the public, providers, or the media could elicit or provide accurate, up-to-date "health information" for integration into daily health practices.

Programs under this sub-IR will be based on a wider lifecycle and/or dual protection perspective. The former implies developing health literacy at a level commensurate with age, mental capacity, gender, and environment. For example, youth can learn about health and hygiene, nutrition and physical activity while learning about reproductive health behavior. The latter implies addressing more than one function of a specific tool, for example, promoting condoms for family planning and for preventing HIV/AIDS and other sexually transmitted disease. Communication can support learning opportunities during immunization experiences such that families and recipients understand the disease preventive and public health benefit of immunizations (and in some cases Vitamin A). As a person ages, an acquired health literacy skill can continue to enhance knowledge and practice and ultimately the health of the public.

[20] BASICS Evaluation, 1997, p.33.
[21] Vicki Freimuth, Huan Linnan, and Polyxeni Potter, "Communicating the Threat of Emerging Infections to the Public," *Emerging Infectious Diseases Journal*, 6:4 (2000).
[22] Scott Ratzan, (ed.) *Health Communication: Challenges for the 21st Century.* American Behavioral Scientist, 1994.
[23] Catherine Selden, et al, (compilers) Health Literacy Bibliography. (Bethesda, MD: National Library of Medicine, 2000).

The integration of research – qualitative and quantitative – will assist the strategic development of health literacy addressing barriers, examining indicators and gauging success.

IR 1.3 also will support programs that actively engage the public and private media in public debate and dialogue on health issues and behaviors. The media industry in partnership with the public health agenda can promulgate health (and wealth) through civic responsibility, global citizenship, environmental justice, gender equality, and health competencies as part of their basic goods and services.

"Social capital" is another area to be explored under IR 1.3. This umbrella concept has been defined as "the resources embedded in social relations among persons and organizations that facilitate cooperation and collaboration in communities." [24] Studies suggest that communal activity and community sharing translates into better health. Evidence suggests that communities with less social capital have lower educational performance, more teen suicide, higher prenatal mortality, and lower birth weight. [25] An IOM publication on promoting health suggests that the media and marketing strategies present a "lever" to enhance social capital. Traditional behaviorally oriented media campaigns, the author notes, have had limited effectiveness in creating and sustaining significant behavior change. Media, however, do have the potential to address more fundamental aspects of the social context in which health behaviors occur, most significantly by enhancing involvement in civic life and encouraging social justice, participation, and social change, thereby contributing to community mobilization to advance public policies that promote health.[26]

Initially programs under IR 1.3 will be carried out by the communication agency. As in-country capabilities grow, this function will be transferred to developing country institutions.

IR. 1.4 Qualitative and quantitative formative, operations, and summative research conducted for ideal communication interventions.

This IR will support efforts to develop research and evaluation to better implement communication programs, training and performance activities, and to demonstrate impact/results. Communication science methodologies include formative research--client needs and preferences, political/social/family context–as well as mechanisms for incorporating these into the design, development, and implementation of program design and execution. Health communication activities may be organized into a formal program to share local experiences, provide specialized technical support, and manage resources. These activities could be integral to the developing country centers of health communication (see IR2) and also IR1 with a consistent enhancement of field-based experiments that refine existing methodologies or develop new approaches.

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[24] K Lochner, et al., "Concepts of Social Capital: Approaches to Measurement. *Health and Place*, 1999.

[25] Ichiro Kawachi and LF Berkman. "Social Cohesion, Social Capital, and Health," in *Social Epidemiology,* LF Berkman et al., (eds.) (New York: Oxford University Press, 1998).

[26] Lawrence Wallack, "The Role of Mass Media in Creating Social Capital: A New Direction for Public Health," in *Promoting Health: Intervention Strategies from Social and Behavioral Research,* B.D. Smedley and S.L. Syme (eds.) (Washington, DC: Institute of Medicine, National Academy Press, 2000).

Many health communication activities are designed with a variety of incentives and disincentives for individuals, providers, institutions and policymakers. Research is necessary at every stage of the communication process to support and sustain the desired outcome for health competence. Appropriate communication research can identify ideal strategies for performance incentives at the system or individual level and also identify the necessary environmental (and in some cases economic) structures that can be enhanced. Ideally, this research and subsequent application will optimize communication effects.

The core-supported component of this sub-IR will contain a research agenda that will address Center-wide needs as well as specific issues within each SO, including the following illustrative list of issues:

1. Analyzing the cost-effectiveness of communication interventions;
2. Assessing dose effects of communication interventions, assessing the incremental effects of each component of multilevel, comprehensive interventions and the incremental effects of interventions over time. Such analyses should consider the broad influence and costs of interventions to target individuals, their families, and the broader social systems in which they operate.[27] ;
3. Improving quality of interpersonal communication such as quality of service delivery, providers' communication skills, participatory methodologies, health literacy, peer exchange among others;
4. Increasing understanding of the impact of culture and gender on the success of communication interventions;
5. Developing new models and measurements of community participation;
6. Gathering and proliferating best practices for sustaining communication campaigns (corporate sponsorship, community ownership, etc.)
7. Assessing and facilitating introduction of IT at all levels of health communication; and
8. Exploring the needs of special audiences.

Further, the multi-disciplinary research approach will devolve the knowledge and know-how of mature disciplines in the North--public relations, media studies, advocacy, social marketing, and community participation/negotiation, public policy etc.--with focused health communication activities in the South. In many ways, the research element is key for IR1. However, its application in IR2 advances the overall sustainability as well as the necessity for integration of communication research at the proximal level of influence. In every case the communication research could assist in the development of the ideal mix of the AAD: partnerships; global leadership; operations and evaluation research; and capacity building, in order to achieve the greatest possible progress in each of the IRs. The following list is illustrative for each SO:

SO1: *Increased use by women and men of voluntary practices that contribute to reduced fertility*
Increasing demand: Research will address how communication variables and activities improve quality of services and client/provider interaction as well as the integration of cultural traditions

[27] IOM , Recommendation 17, 2000, p.29.

and beliefs—adapting normative behavior. Communication/Social marketing research will help refine audience segmentation for improved message reception and more effectively reach youth, partners, social networks, and the community at large. Finally, evidence based research can be employed to dispel misconceptions and myths about methods.

Exploration of communication variables that lead to a decrease of contraceptive discontinuation rates and the activities necessary to sustain use and reverse misuse can also be developed.

SO2: *Increased use of key maternal health and nutrition interventions*
Advocacy: Research will develop and test advocacy tools to include practical, actionable recommendations for interventions at the community, regional, policy, and national level

Connecting women with services: Research will address how to use communication more effectively to reduce the cultural, physical and other barriers to women seeking services or adapting healthy behaviors.

SO3: *Increased use of key child health and nutrition interventions*
Immunization: The main areas of research include how to use communication more effectively to: generate and sustain demand among child caretakers for immunization services; improve bottom-up or participatory planning to reach high-risk populations and promote community ownership and support. Other areas are how to use communication to build inter-sectoral alliances and widespread participation of community-level influentials and organizations, administrative authorities, and institutions to support specific initiatives such as polio eradication and periodic measles and tetanus campaigns and enhance the longer-term sustainability of health system immunization services. Finally, as with all SO3 activities, research will address how to improve the communication skills of health workers as service providers and supervisors or managers.

Nutrition: Research will address how to employ communication more effectively for behavior change activities at household, community, policy, and health system levels and how to link community-based nutrition interventions with the larger health system.

Integrated approaches to child health: Research will address how to employ communication more effectively to improve caretaker practices within the household – recognizing severe illness, seeking appropriate care, compliance with treatment recommendations, maintaining good home hygiene as well as the effective use of communication to address barriers to compliance, implemented through various community agents, health workers, and targeted mass media.

Peri/neonatal health: Research will address how to employ communication more effectively to support community mobilization and participation, improve practices of healthcare providers, and increase the awareness of policy and decision-makers of the importance of newborn care and the need for appropriate programs.

SO4: *Increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic*

Awareness and prevention: Research will address how communication can effectively help set the agenda for heightened community awareness, mobilization and participation, improve practices of healthcare providers, and increase the awareness of policy and decision-makers of the magnitude of HIV impact.

Research will develop and test advocacy and communication tools to include practical, actionable recommendations for interventions at the community, regional, policy, and national level in health settings, public discourse and policy environments.

Reducing stigma: Research will develop and evaluate communication interventions to reduce stigma, discrimination and hopelessness associated with HIV. Linkages with other SO efforts and dose effect of family planning, STI education, and emerging diseases will further be explored for potential synergies and/or diluted effects. In particular, the role of culture as an asset and a barrier will be explored.

SO5: *Increased use of effective interventions to reduce the threat of infectious disease of major public health importance*
Going to scale with successful interventions: In general, research will evaluate smaller-scale, experimental interventions to employ communication to change behaviors under SO5 and assess needed factors in order to take interventions to a larger scale. Cross cutting research areas for SO5 are how to use communications more effectively to reduce stigma and increase patient compliance. In the case of malaria, research will address the issue of how to improve social marketing of products and change caretaker behaviors as well as group preventive behaviors within the family,

IR 2 Country-level leadership to deliver communication programs strengthened

- IR 2.1 In-service training and pre-service education for health communication developed in countries
- IR 2.2 Capacity developed in countries via centers of health communication, networks and other activities.
- IR 2.3 Qualitative and quantitative formative, operations, and summative research capacity and diffusion developed in countries.

The ten-year vision of the Communication AAD is the devolution of the implementing capacity for health communication programs to developing country institutions. A parallel to this devolution will be the enhancement of the capacity of USAID Missions, partners and programs to manage large-scale health communication programs in countries and regions (IR1.1). The results of this IR will be measured in terms of the improved capacity and sustainability of local and regional institutions and networks. Core, field support, and mission-based procurement actions will support activities.

IR 2.1 In-service training and pre-service education for health communication developed in countries

USAID along with a score of international and bilateral agencies such as the Pan American Health Organization, World Bank, Inter American Development Bank, UNICEF, and Rockefeller Foundation currently are supporting health communication programs in developing countries with high levels of funding. Funding, however, does not necessarily contribute to building capacity in country, and developing countries' capacity to implement health communication programs remains limited. There are only a small number of professionals in developing countries with advanced degrees in health communication theory, methods, practice, and research. In fact, while there has been significant development of health communication as a field in the United States, very few universities in developing countries offer undergraduate or graduate programs in this field.

Activities under this AAD will address the current shortage of health communication professionals in developing countries. It will build academic infrastructure and create regional self-sufficiency. By the end of the ten-year period we expect a number of the research, planning, implementation and evaluation of health communication programs supported by USAID will be carried out in local and regional institutions. A procurement under this activity will help develop templates, competencies, core curriculum, instructional design, technological applications, South-South support and regional coordination while working closely with Mission programs already addressing this need.

Programs under this sub-IR could include:

- Support of universities as institutions and/or a consortium to identify core competencies and develop and implement degree and certificate program in health communication in schools of public health, communication and journalism.
- Support to improve programs, and practices, through site visits, exchange programs, lectures, on-line discussions, one-to-one local tutoring on topics such as communication for development, program planning and evaluation, partnership building, behavioral change theories and methods, use of epidemiological data, research design, curricular and faculty development, and program marketing.
- Development and testing of interactive multimedia and on-line exchange and education resources in health communication.
- Support to local, national, sub-regional and regional networks (real and electronic) of health communication scholars, practitioners, or journalists and connection with worldwide networks.
- Training of university faculty and training of trainer programs
- Partnerships with NGOs, multilateral institutions, national and local governments, and private organizations, to promote the benefits of employing health communication professionals and supporting research and development projects.

IR 2.2 Capacity developed in countries with Centers of Health Communication, networks and other activities.

In collaboration with field missions, sub-IR 2.2 will provide support for building capacity by establishing Centers of Health Communication (COHC) and health communication networks in countries and regions. These institutions could be specialized by topic, for example, a center on health communication for HIV/AIDS, TB, or malaria, or by region. These centers will provide the essential infrastructure needed to facilitate rapid advances in knowledge about health communication, develop evidence-based strategies and tools for health communication, train tomorrow's health communication scientists and promote collaboration with medical centers of excellence and partnerships with advocacy groups, industry and commercial endeavors.

An important role of the centers will be to study how to maximize the impact of communication for health competence including social and behavioral elements. Evidence based research – formative, operations and evaluation – will be supported in the in-service and pre-service training as well as amongst those professionals affiliated with the COHC. It is envisioned that areas of communication expertise would emerge and be developed and their success could be diffused through out the region or globally. For example, a COHC might address HIV/AIDS with a specific communication intervention to reach illiterate women or other at-risk and under-served populations. Improved efficacy of public opinion polling, public relations, marketing communication, interpersonal communication, advocacy, community mobilization and media strategies will be hallmarks of the COHCs that influence health activities at the global, regional and local levels.

These Centers of Health Communication can be based in existing institutions, such as medical schools, schools of public health, communication or journalism or similar existing organizations. Depending on the infrastructure and status of such institutions in country, health communicators in the North will link with their counterparts at the COHC that may include people from academic, governmental and professional institutions. The centers and their counterparts will be strengthened by ready access to the Media Materials Clearinghouse, an internationally recognized health communication database that USAID has developed over ten years, as well as to the Internet. The clearinghouse, currently housed under the PIP project at JHU/CCP, will become part of the "assets" of the new program under this AAD. This clearinghouse serves as the "core library" of materials for health communication interventions with CD-ROMs, evidence-based approaches, and multi-media archives.

A wide range of activities in communication can be developed in the form of networks. In resource-poor environments, health communication practitioners often work in a relative vacuum, and key public health information cannot be integrated by central authorities or by the people inputting information into the surveillance network. The COHC can link practitioners working in the field with public health academics and students. A network benefit includes capacity building through curriculum co-development, a process wherein North and South instructors develop parallel courses. The contents of these courses and their products are shared interactively by students and faculty, expanding the 'vision of the possible' in and outside the classroom.

Networks also can strengthen the ability of broadcast and newspaper journalists, government spokespeople, NGOs, health professionals, educators, and private sector communicators to

enhance health literacy, promote healthy choices and behaviors, and influence public policy. The lessons learned since 1997 from the European Health Communication Network (EHCN) experience include activities of 51 WHO European Member States. This network created synergistic links as people in the networks develop appropriate health information sources linking distribution resources and appropriate agendas for their constituencies.[28]

IR 2.3 Qualitative and quantitative formative, operations, and summative research capacity and diffusion developed in countries

This sub-IR will support efforts to develop research and evaluation capacity to better implement communication programs, training and performance activities, and to demonstrate impact/results. Communication science methodologies include formative research--client needs and preferences, political/social/family context–as well as mechanisms for incorporating these into the design, development, and implementation of program design and execution. Health communication activities may be organized into a formal program to share local experiences, provide specialized technical support, and manage resources. These activities could be integral to the Center of Health Communication and also IR1 with a consistent enhancement of field-based experiments that refine existing methodologies or develop new approaches. In summary, the development of capacity for research in IR2 advances the overall sustainability as well as the necessity for integration of communication research at the proximal level of influence. The COHC and the people they train should continue to imbue the ideal approach to health communication activities. In every case communication research could provide evidence for the ideal mix of strategic design and program implementation.

IR 3 Knowledge, best practices and policies for health and population identified, published, disseminated and utilized

- IR 3.1 Information on useful/best approaches widely disseminated to multiple audiences
- IR 3.2 New communication technologies applied to manage, disseminate and share information
- IR 3.3 South-South and South-North communication networks created and enhanced
- IR 3.4 Information and knowledge shared to contribute to and influence the global agenda on population and health

IR 3.1 Information on useful/best approaches widely disseminated to multiple audiences.

PIP, the current POP vehicle, provides the most relevant and up-to-date information and materials in the field of fp/rh and other related areas to developing country family planning/reproductive health specialists, policy makers, researchers, journalists, academics, and

[28] World Health Organization (WHO) "The Pen is as Mighty as the Surgeon's Scalpel: Improving Health Communication Impact." Proceedings of the WHO European Health Communication Network Consultation on Health and Environmental Communication Policy, Moscow, 28-30 May, 1998.

communication specialists. This service will continue to be provided under this AAD through a competitively bid cooperative agreement. The new CA will utilize a variety of media such as journals, other publications, CD-ROMs, the Internet and electronic media. The result of this sub-IR will be improved quality of decision-making and care provided in family planning and reproductive health programs and services and improved quality of strategic management and policy formulation in these programs.

IR 3.2 New communication technologies applied to manage, disseminate and share information.

In the past 10 years a revolution has occurred in terms of how information is produced, disseminated and shared. While most professionals in developed countries can retrieve information with relative ease via personal computer, the Internet, cell phones and other means, many professionals in developing countries must continue to rely on print publications received through donor organizations, ministries of health, and foundations. The one exception is CD-ROMs that for a number of years have been distributed to fp/rh specialists in developing countries. Currently PIP distributes CD-ROMs to more than 500 organizations in 95 countries. This technology enables fp/rh professionals to conduct research and remain up-to-date on the latest developments, practices and research in the field.

Within the next five to seven years the landscape likely will have changed to allow fp/rh specialists in developing countries to be as "connected" as their developed country counterparts. Under this sub-IR, programs such as portals, networks, search engines and other Internet services will be developed, promoted and used for and by developing country professionals. Programs also will provide training and technical assistance on the use of information tools. The result of this sub-IR will be improved capacity of developing-country institutions to serve local needs for scientific, technical and programmatic information in the field of fp/rh.

IR 3.3 South-South and South-North communication networks created and enhanced.

Historically, developed country scientists and policy makers have produced and disseminated family planning, reproductive health and primary health information to their colleagues in developing countries. The result has been a "one-way street" on which information mainly flowed from developed country specialists to developing country professionals. This led to missed opportunities for information sharing between developed and developing country specialists and among developing country specialists.

Under this AAD information centers and "networks" will be formed that allow fp/rh providers, program planners and policy makers in the South to communicate directly with each other and with their colleague in the North, helping to create a worldwide and common base of knowledge for practice and policy.

IR 3.4 Information and knowledge shared to contribute to and influence the global agenda on population and health.

While information about USAID family planning, reproductive health and primary health programs, successes and lessons learned have been shared for years, under this sub-IR it is expected that the reach and scope will increase. By providing relevant and up-to-date materials, publications, searches and other information services to family planning/reproductive health service providers, policy makers, journalists, academics and researchers, the knowledge base of those providing services, setting priorities and formulating policies will greatly increase. In addition, by highlighting the achievements and potential of fp/rh programs in reducing birthrates, improving maternal and child health, enhancing the welfare of families, enabling women to take new opportunities and slowing environmental degradation and resource depletion, it is hoped that this will encourage greater commitment and support from additional public and private sources to these programs.

V. FINANCIAL PLAN

(a) Total Funding Levels

Total USAID funding for this cooperative agreement will have a ceiling of $xxx million over the ten-year implementation period. This includes G/PHN core funds and field support funds from USAID missions and regional bureaus.[29] Total program costs, including program income from other sources, are expected to total about $xxx million.

(b) Funding Accounts and Sources

- Actions under this AAD will be able to receive funds from a variety of foreign assistance accounts and funds:

Funding for this Communication AAD is expected to come from multiple budgetary sources:
- G/PHN core Population, Child Survival, Maternal Health and Nutrition, HIV/AIDS, and Infectious Diseases budgets;
- USAID Regional Bureau and Mission Field Support budgets for Population, Child Survival, Maternal Health and Nutrition, HIV/AIDS, and ID budgets;
- Global Bureau and Field Support funds from other USAID earmarks and accounts, e.g., CSD funds for girls' education, DG;
- Funds from other donors, especially private foundations;
- In-kind and cash contributions from national and local governments and NGOs in developing countries for implementation of country programs;
- Matching funds provided by cooperating agencies/implementing partners.

[29] "Core" PHN funds are provided centrally from the USAID/Global Bureau/PHN Center budget; "Field Support" funds are USAID Mission and Regional Bureau funds that the Mission/Bureau requests G/PHN to obligate to acquire services from a centrally-managed agreement in support of the Mission's/Bureau's strategic objectives.

(c) Use of Core and Field Support Funds

The project will have a sound base with core PHN funds [and Regional Bureau Field Support] to fulfill its technical leadership role, including research, dissemination, capacity-building and coordination activities.

(d) Programmatic and Geographic Allocation of Funds

For illustrative purposes, the following guidance is provided on the allocation of funds by major program areas and regions:

- Over the life of the agreement, it is envisioned that approximately 65 percent of total USAID resources will be allocated for country program implementation support, 20 percent for technical leadership activities and capacity building, and 15 percent for knowledge management and dissemination activities.
- Roughly 40 percent of country program implementation support activities are envisioned to take place in the sub-Saharan Africa region, 30 percent in Asia and the Near East, 15 percent in Latin America and the Caribbean, and 10 percent in Europe and Eurasia. About 5 percent of the activities will be global in scope. The actual distribution of funds and activities across regions, however, will depend on individual Mission interest and availability of Field Support funds.

(e) Cost-Sharing and Program Income

Partners should work towards a significant cost-sharing target of 15 percent of USAID obligations. Such funds may be mobilized from their own funds, from other multilateral, bilateral and foundation donors, and from host governments or local universities, communities and private businesses that contribute financially and in-kind to implementation of activities at the country level.

As G/PHN's technical leader in communication, the project is expected to mobilize substantial additional program income from other donors. For example, it is envisioned that funds for activities from private foundations focusing on leadership, communication and social change will be leveraged for these activities. In addition, this activity can mobilize funds to help support linkages with other parts of USAID – e.g. conflict mitigation/Health as a Bridge to Peace and broader development activities such as non-formal education, vocational training and formal education programs. Funds for cross-sectoral activities may be mobilized from other USAID sectors and from other donors, national and local governments, universities, local communities and private businesses.

Procurement Mechanism (deleted)
Management Section (deleted)

VI. ANALYSES

(a) Stakeholder Analysis

This AAD is built on a fundamental understanding of the knowledge base to date on communication. Information has been compiled through the published literature, USAID reports, field reports, mission surveys, experiences of country implementers, cooperating agencies/stakeholders and input from PHN Center activities.

In preparing the AAD, G/PHN engaged in a variety of activities with potential interested parties, other donors, USAID Missions and Bureaus, and other key actors. The first activity included gathering information on what has been done and documented in the field of population and health mass-media communication from 1990-2000. A bibliography of 283 articles was created and a research team reviewed 67 of these articles that were selected on the basis of date published, the article assessed impact and included a mass-media component. The literature review assessed the impact of the various types of mass-media communication interventions with particular emphasis on the level of impact in relation to various other components—theory base, timeframe, and others. Overall, the findings supported investments in communication, attributing significant impact to communication elements. The review of the literature suggested that current and past approaches in health communication are not integrative and evidence-based in the theoretical and practical approaches that impact population-based health behavior change.[30]

Consonant with other studies in this area, including those previously cited in this document by the Institute of Medicine and the National Academy of Sciences, the review indicates that systematically developed strategic communication maximizes impact in PHN and HIV/AIDS with emphasis at the individual, community, professional, policy and social level. This literature review was presented at the Stakeholders meeting and will be submitted to *International Family Planning Perspectives.*

Also contributing to the current AAD were recommendations from an external evaluation of the PCS project conducted in early 2001. Team members included international communication experts with experience in strategic planning, implementation, and evaluation of communication programs in the developing world. The evaluation found the current project had been generally successful in meeting its objectives and that their work had contributed to lasting beneficial changes in health behaviors as well as to significant advances in development communication science and practice. The proposed AAD addresses the four areas that the evaluation team identified as needing increased attention in USAID's next communication project:

- Expanding the focus beyond individual behavior change and increasing the emphasis on factors related to broader social change.

[30] CT Orleans. "Promoting the Maintenance of Health Behavior Change: Recommendations for the Next Generation of Research and Practice." *Health Psychology*, 2000 19: 1 (suppl.), 76-93.

- Expanding the project's advocacy role to influence decision-makers and policy and regulatory environments, including the use of community advocacy in addressing issues resulting from decentralization.
- Establishing meaningful and measurable standards of performance recognizing the difficulty in establishing causality with communication interventions. This will be particularly relevant for community mobilization activities, as measuring their impact is more complex.
- Intensifying the development of communication skills in host countries that can then be used for technical assistance and training support.[31]

Field perspectives and opinions have been crucial to the design process. Early on in the information gathering stage, USAID field missions were surveyed using a questionnaire that asked about their current and future communication priorities and activities and perceived gaps or emerging issues that the project should address. Almost 50 percent of the 57 missions surveyed responded to the questionnaire, and all indicated that they planned to implement communication activities in the next five years. As mission-funding trends have shown in recent years, most missions plan to use communication across SOs— family planning, HIV/AIDS, infectious disease, and child survival were mentioned most often. Mass media and IEC materials are the two most commonly sited types of communication interventions planned. Community mobilization and interpersonal communication also were mentioned frequently, followed by social marketing. Gaps and emerging issues that the field hoped the new project would address included infectious disease (TB was most often named specifically, HIV/AIDS and malaria less often). Addressing the needs of adolescents and developing/expanding private sector partnerships were noted as high priorities, and policy/advocacy and research (tools, M&E, documenting successes) also surfaced as future needs.[32]

The Communication AAD Team also invited one PHN Officer from each region to be a "virtual" team member. Colleagues were selected who had some experience in communication and had managed substantial communication projects in the past. Virtual members have received key documents and provided input on draft frameworks and earlier versions of this document.

Finally, as part of the design process a short questionnaire was sent to 60 people active in health communication in developing countries not affiliated with US-headquartered international development agencies. Their contributions help support the conceptual framework and design. In particular, they expressed the need for a multi-disciplinary approach with a variety of messages and channels. One of the more notable findings was the fact that communication challenges are often organizational: the agency, department, project, leadership etc. did not understand the impact potential or use of communication. In fact, many identified the low status (pecking order) often associated with communication. The Centers of Excellence in IR2 and the multi-disciplinary basis for the entire AAD address these observations that also are consonant with the published literature and other information sources.

(b) Social/Gender Analysis

[31] PCS Evaluation, 2001, pp. 65-67.
[32] USAID Mission Survey, November 2000.

Addressing social/gender issues will be an integral part of this AAD. Communication programs ultimately influence prevailing social norms including the value of women and gender equity, the roles women can and should play in both the home and society, and partner communications and attitudes about sexual and physical violence. Gender is an important variable, therefore, in segmenting audiences for impact in FP/RH, HIV/AIDS and related health challenges.

Involving men in reproductive health programs has become increasingly important in G/PHN. Men are a key audience for health messages. As the primary and sometimes sole decision-maker in the family unit, they often control vital resources for accessing health services—fees for clinic visits, transportation to facilities, etc. The activities under this AAD will look at new ways to engage men in health decisions, through a combination of approaches--debate and dialogue on certain cultural practices, through peer communication, or targeted mass-media campaigns.

Addressing the reproductive health needs of youth (including HIV/AIDS and STI prevention) has also become a clear priority for USAID at both the global and field level, but program experience to date, both by USAID and other donors, had been small-scale and lacking in rigorous evaluation.[33] The current POP communication project has devoted about one-third of its resources to reaching youth and appears to be producing genuine impact among this population.[34] Communication programs can help young males recognize that sexual pressure, violence or coercion of any kind is unacceptable, develop more respectful attitudes to girls, and assume greater responsibility for prevention of disease (STIs/HIV) and reproductive health. Activities under this AAD will continue to provide expertise to the field in creating communication interventions that resonate with youth.

The evaluation of the current POP communication project recommended that the gender focus of the project be improved by systematically integrating and acting upon gender analysis in all stages of program cycles and by mainstreaming gender to the project's training materials and approaches[35]. Given this AAD's switch in focus from individual behavior change factors related to broader social change, it is critical that gender –the different roles, responsibilities and opportunities of men and women in society-- be addressed throughout the IRs and sub-IRs.

(c) Technical Analysis

A growing body of literature is beginning to demonstrate the effects of communication interventions on changing individual and community behaviors in the areas of population, health and nutrition. Communication also has demonstrated success in:

[33] Judith Sendorwitz, "A Review of Program Approaches to Adolescent Reproductive Health," (Washington DC: Population Technical Assistance Project, 2000).
[34] PCS Evaluation, 2001, p. 26.
[35] PCS Evaluation, 2001, p. 52.

influencing the public agenda, advocating for policies and programs, promoting changes in the socioeconomic and physical environments, improving the delivery of public health and health care services, stimulating debate and dialogue for health as a priority, and encouraging social norms that benefit health and quality of life.[36]

The programs designed under this AAD are based on a clear understanding of what works and of the steps needed to increase the impact, cost effectiveness and sustainability of USAID's communication portfolio. This project has been developed and guided by a Center-wide technical team that held numerous meetings and discussions, sharing experience, Center/field needs and a variety of evidence-based ideas. This AAD was predated by a Concept Paper that built on evidence-based conceptual framework(s) as well as the historical approaches in health communication employed to address the field needs and Center objectives.[37]

The design of the AAD also reflects the fact that as the world's largest donor in the field of health communication, USAID's has a two-fold responsibility to: 1) Provide USAID Washington and field missions world-class vehicles for implementing communication and advocacy programs within their PHN portfolios, and 2) Ensure the transfer of communication capacity and leadership to training institutions and centers of excellence in the developing world.

The understanding that no one size fits all is fundamental to the understanding of the impact of communication. Communication is not a simple solution to a complex problem. Communication is complex, dynamic and requires unique know-how and strategic thinking. For this reason and given the different needs of the G/PHN SOs and of the field missions, the programs under this AAD will range from basic formative and operations research on what works for newer areas such as TB and AMR to questioning or exploring how to change social norms, achieve sustainability and go to scale for more mature family planning programs. This AAD provides mechanisms for strategic diagnoses, cutting edge innovation, and taking to scale and transferring what is known.

Effective communication is strategic as well as evidence-based; it is not just message repetition. Effective communication leads to community capacity to espouse common values of health. Attaining the Agency's goals in population, health and nutrition means communicating well with

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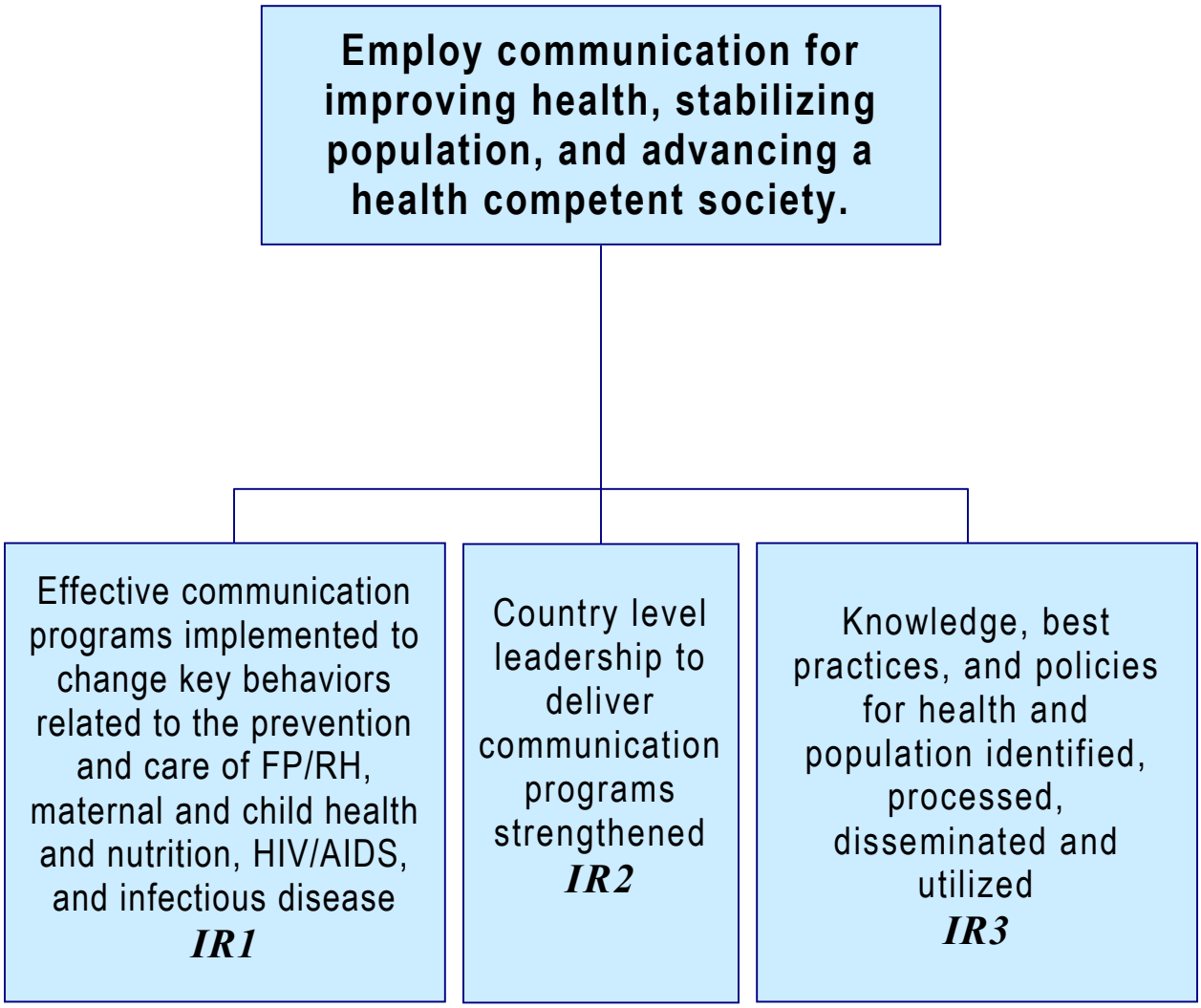
[36] IOM, 2000.

[37] R.G. Evans and G.L. Stoddart, "A Model of the Determinants of Health: Predicting Health, Consuming Health Care," *Social Science Medicine,* 31:1347-63, 1990.
Scott Ratzan, "USAID Communication Activity Acquisition Document Concept Paper," January 2001.

individuals, families and communities. It also means communicating effectively to policymakers and leadership outside of the health sector and making them aware of the critical elements that contribute to health.

VIII. COMMUNICATION AAD CONSTRUCT



DRAFT GLOSSARY OF HEALTH COMMUNICATION TERMS

DRAFT June 1, 2001

The glossary consists of terms commonly used in policy and advocacy initiatives related to health communication. The list is presented in alphabetical order.

Whenever possible, definitions have been taken or adapted from official publications. When appropriate, the source of different terms has been given in the text. Some of the definitions are original to the glossary, or are composites of definitions that reflect different perspectives to the term cited. The bibliography lists all the sources referred to directly in the text.

Some terms within the definitions and notes are highlighted in *italics* to assist the reader in cross-referencing with other definitions. This cross-referencing is intended to improve understanding of the inter-relationships between different terms and concepts.

Terms

Advocacy
Appeal
Attitudes
Audience Segmentation
Audience Profile
Behavioral Characteristics

Campaign

Capacity Building
Channel
-Interpersonal channel
-Mass-media channel
-Organizational channel
-Small group
Communication
Communication for Social Change
Communication for Development
Community
Community Media
Community Mobilization
Community Participation
Cost/benefit Evaluation
Cost-effectiveness Analysis
Demographics
Determinants
Development Communication
Diffusion
Dual Protection
Efficacy
Entertainment-Education
Environmental Factor
Epidemiology
Evaluation
-- Exposure
-- Formative
-- Implementation
-- Outcome
Evidence-based
Fear
Gatekeeper
Gender
Geodemographics
Goal
Health
Health Behavior
Health Communication
*Health Competent
Health Development
Health Education
Health Information
Health Indicator
Health Literacy
Health Policy
Health Promotion
Health Status
Health Target
Key Informants
Lifecycle

Media Advocacy

Mediation
Motivators
Needs Assessment
Negative Appeal
Negotiation
Network
Opinion Leader
Outcome
Positive Appeal
Psychographics
Risk Communication
Risk Factor
Self-efficacy
Situational Analysis
Social Capital
Social Environment
Social Marketing
Social Networks
Social Norms
Social Support
Stakeholders
Stigma
Surveillance
Sustainable Development
Target Audience
-Primary audience
-Secondary audience

Communication Glossary
DRAFT VERSION JUNE 1, 2001
drafted by USAID

Advocacy

A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular *goal* or program. (WHO, 1995)

Appeal

A message quality that can be tailored to one's *target audience*(s). This term refers to the motivation within the *target audience* that a *message* strives to encourage or ignite (e.g., appeal to love of family, appeal to the desire to be accepted by peer group). (CDC, 1998)

Attitudes

An individual's predispositions toward an object, person, or group, that influence his or her response to be either positive or negative, favorable or unfavorable. (CDC, 1998)

Audience Segmentation

The process of dividing a target population group into homogeneous subsets of audience segments based on some common factors related to the problem, usually behavioral determinants or psychographic factors to better describe and understand a segment, predict behavior, and formulate tailored *messages* and programs to meet specific needs. (Adapted from CDC, 1996; CDC, 1998)

Audience Profile

A formal description of the characteristics of the people who make up a *target audience*. Some typical characteristics useful in describing segments include media habits (magazines, TV, newspaper, radio, and Internet), family size, residential location, education, income, *lifestyle* preferences, leisure activities, religious and political beliefs, level of acculturation, ethnicity, ancestral heritage, consumer purchases, *psychographics*.(CDC, 1998)

Behavioral Characteristics

Activities in which people do (or do not) engage that are relevant to the health problem or to how they might be reached and influenced. Behavioral characteristics are useful for *audience segmentation*. (Adapted from: CDC, 1998)

Campaign
Goal-oriented attempts to inform, persuade, or motivate behavior change in a well-defined audience. Campaigns provide non-commercial benefits to the individual and/or society, typically within a given time period, by means of organized communication activities. (Centre for Health Promotion, 1996.)

Capacity Building

Equipping people to effectively take control of their own development by strengthening their knowledge, skills, confidence and personal esteem. The concept can be applied to individuals, groups and organizations. (UNICEF, 2001)

Channel

The way in which individuals receive information (CDC, 1996)

Interpersonal Channel

A *channel* that involves dissemination of *messages* through one-on-one communication (e.g., mentor to student, friend to friend, pharmacist to customer). (CDC, 1998)

Mass-media Channel

A *channel* through which *messages* are disseminated to a large number of people simultaneously (e.g., radio, TV, newspapers, billboards). (CDC, 1998)

Organizational channel

A *channel* through which *messages* are disseminated at the organizational level (e.g., corporate newsletters, cafeteria bulletin boards). (CDC, 1998)

Small group channel

A *channel* through which *messages* are disseminated at the small-group level (e.g., meetings on health topics, cooking demonstrations). (CDC, 1998)

Communication

The exchange and sharing of information, *attitudes*, ideas, or emotions. (Centre for Health Promotion, 1996.)

Systematic, informed creation, dissemination, and *evaluation* of *messages* to affect knowledge, skills, *attitudes*, beliefs, and behaviors. (CDC, 1996)

Communication for Social Change

A process of public and private dialogue through which people define who they are, what they want and how they can get it. Social change is defined as a change in people's lives as they themselves define such change. This work seeks particularly to improve the lives of the politically and economically marginalized, and is informed by principles of tolerance, self-determination, equity, social justice and active participation for all. (Rockefeller Foundation, 1999)

Communication for Development ***(see also Development Communication)***

A research and planned process, crucial for social transformation, operating through three main strategies: *advocacy* to raise resources and political and social leadership commitment for

development goals; *social mobilization* for wider participation and ownership; and *program communication* for changes in knowledge, attitudes and practices of specific participants in programs. (UNICEF, 2001)

Community

A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, and are arranged in a social structure according to relationships which the group has developed over a period of time. (WHO, 1998)

Community Media

Media owned, controlled and produced by, for and about communities. (Communication Initiative)

Community Mobilization

A process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups and organizations on a participatory and sustained basis to improve health. In addition to improving health, the community mobilization process also aims to strengthen the community's capacity to address its health and other needs in the future. (Save the Children)

Community Participation

The educational and empowering process in which people, in partnership with those able to help them, identify problems and needs and increasingly assume responsibility for planning, managing, controlling and assessing the collective action that needs to be taken. (Askew, et al, 1986)

Cost/benefit Evaluation
Examines the overall cost of a program compared to the dollar value of the effects that can be attributed to the program. These two values yield a cost-benefit ratio. (CDC, 1998)

Cost-effectiveness Analysis

A management tool that generates estimates of the cost per unit of achieving various "outputs" using different combinations of "inputs." It is useful for identifying successful (low-cost) program sub-components, problem (high-cost) areas and achieving the maximum performance levels at the least cost per unit. (Warner and Luce, 1982)

Demographics

Statistics relating to human populations, including size and density, race, ethnicity, growth, distribution, migration, births, deaths, and their effects on social and economic conditions. This data can be useful for defining the *target audience* and understanding how to communicate more effectively with the *target audience*. (Adapted from: CDC, 1998; CDC, 1996)

Determinants

External and internal personal, social, economic and environmental factors that determine the *health status* of individuals or populations. (WHO, 1998)

Development Communication (see also *Communication for Development*)
The strategic application of communication technologies and processes to promote social change. (Wilkins, 2000)

Diffusion

The process by which an innovation is communicated through certain *channels* over time among members of a social system. (Rogers, 1995)

Dual Protection

Protection from pregnancy and STIs/HIV either through the use of a condom alone or the use of a condom plus another contraceptive method. Abstinence, or avoidance of penetrative sex, is another means of achieving dual protection. (USAID, 2000)

Efficacy

The power to produce a desired effect or intended result or *outcome*. (Neufeldt, 1991)

Entertainment-Education (Edutainment, Enter-Educate, Infotainment)
The science and art of consciously integrating educational messages into popular media entertainment formats -- such as soap operas, talk shows, comic books, and rock music - in order to show people how they can live happier and healthier lives.

The process of purposely designing and implementing a media message both to entertain and educate, in order to increase audience members' knowledge about an educational issue, create favorable attitudes, and change overt behavior (Singhal and Rogers, 1999).

Environmental Factor

A component of the social, biological, or physical environment that can be causally linked to the health problem. (Adapted from: Green and Kreuter, 1991)

Evaluation

A systematic process that records and analyzes what was done in a program or intervention, to whom, and how, and what short- and long-term behavioral effects or *outcomes* were experienced. Types of evaluation include *exposure*, *formative*, *implementation*, and *outcome evaluation.* (CDC, 1998; CDC, 1996).

Exposure evaluation

An *evaluation* of the extent to which a *message* was disseminated (e.g., how many members of the *target audience* encountered the *message*). However, this type of *evaluation* does not measure

whether audience members paid attention to the *message* or whether they understood, believed, or were motivated by it. (CDC, 1998)

Formative evaluation

An *evaluation* conducted during program development that measures the extent to which to concepts, *messages*, materials, activities, and *channels* meet researchers' expectations with the *target audience*. (CDC, 1998)

Implementation evaluation

An *evaluation* of the functioning of components of program implementation. Includes assessments of whether materials are being distributed to the right people and in the correct quantities, the extent to which program activities are being carried out as planned and modified if needed, and other measures of how and how well the program is working. Also called process evaluation. (CDC, 1998)

Outcome evaluation

A type of *evaluation* that determines whether a particular intervention had a desire impact on the targeted population's behavior, i.e., whether the intervention provided made a difference in knowledge, skills, *attitudes*, beliefs, behaviors, and health *outcomes*. Also called impact or summative *evaluation*. (CDC, 1996)

Evidence-based

The content and strategies are based on formative or previous evaluation with the intended audience and on applicable findings from previous communication research. (Ratzan, 1998)

Fear

A mental state that motivates problem-solving behavior if an action (fight or flight) is immediately available; if not, it motivates other defense mechanisms such as denial or suppression. (Green and Kreuter, 1991)

A fear appeal is an attempt to elicit a response from the *target audience* using *fear* as a motivator (e.g., fear of injury, illness, loss of a loved one). (CDC, 1998)

Gatekeeper

An influential individual who serves as an access point to the *target audience*. (CDC, 1996)

Gender

A sociocultural variable referring to the roles, behavior and personal identities that the society or culture proscribes as proper for women and men. These attributes are, opportunities, and relationships are socially constructed and learnt through socialization processes. Gender roles vary across determinants such as race, culture, community, time ethnicity, occupation, age, level of education. While sex is biological, gender is socially defined. (Mendoza, 1997)

Geodemographics

Geographic factors and trends in a specific locale (e.g., where people live, population density, healthcare, climate, eating patterns, spending patterns, leisure activities, local industry, and outdoor activities) that can help with locational decisions (e.g., selecting a clinic site) or local contact interventions. (CDC, 1998)

Goal

Summarize the *outcomes* which, in the light of existing knowledge and resources, a country, *community*, organization, or individual might hope to achieve in a defined time period. (Adapted from: WHO 1998)

Health

A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. (WHO, 1948)

Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. (WHO, 1986)

Health Behavior

An action performed by an individual that can negatively or positively affect his or her *health* (e.g., smoking, exercising). (CDC, 1998)

Health Communication

The art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. Its scope includes disease prevention, health promotion, health care policy, business, and the enhancement of the quality of life and health of individuals within the community (Ratzan et al, 1994, cited in Healthy People 2010)

The study and use of communication strategies to inform and influence individual and *community* decisions that enhance *health*. (CDC, 1998)

The process and effect of employing ethical persuasive means in human *health* care decision-making. (Ratzan, 1993)

A key *strategy* to inform the public about *health* concerns and to maintain important *health* issues on the public agenda. The use of the mass and multi media and other technological innovations to disseminate useful *health* information to the public, increases awareness of specific aspects of individual and collective *health* as well as importance of *health* in development.

Health communication is directed towards improving the *health status* of individuals and populations. Research shows that theory-driven mediated health communication programming can put *health* on the public agenda, reinforce health messages, stimulate people to seek further information, and in some instances, bring about sustained healthy *lifestyles*.

Health communication encompasses several areas including entertainment-education, health journalism, interpersonal communication, media *advocacy*, organizational communication, risk communication, social communication and *social marketing*. It can take many forms from mass and multi media communications to traditional and culture-specific communication such as story telling, puppet shows and songs. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas. (adapted from WHO, 1996)

Health Competent

Possessing the necessary elements for optimal health performance, namely a supportive environment, an effective system, and health literate individual/public. (Ratzan, 20001)

Health Development

The process of continuous, progressive improvement of the *health status* of individuals and groups in a population. (WHO, 1997b)

Health Education

Consciously constructed opportunities for learning involving some form of communication designed to improve *health literacy*, including improving knowledge, and developing *life skills* that are conducive to individual and *community health*.

Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (*self-efficacy*) necessary to take action to improve *health*. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on *health*, as well as individual *risk factors* and *risk behaviors*, and use of the health care system.

Health Indicator

A characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the *health* of an individual or population. (WHO, 1998)

Health Literacy

The cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good *health*. Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and *community health* by changing personal *lifestyles* and *living condition*s. (WHO, 1998)

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.(National Library of Medicine, National Institutes for Health, 2000)

Health Policy

A formal statement or procedure within institutions that defines priorities and the parameters for action in response to health needs, available resources and other political pressures. (WHO, 1998)

Health Promotion

The process of enabling people to increase control over the *determinants of health* and thereby improve their *health*. There are three basic health promotion strategies. These are: *advocacy* for health to create the essential conditions for *health* indicated above; *enabling* all people to achieve their full health potential; and *mediating* between the different interests in society in the pursuit of *health*. (WHO, 1986)

Health Status

A description and/or measurement of the *health* of an individual or population at a particular point in time against identifiable standards, usually by reference to *health indicators.* (Adapted from: WHO, 1984)

Health Target

The amount of change (using a *health indicator*) within a given population which could be reasonably expected within a defined time period. Targets are generally based on specific and measurable changes in *health outcomes*. (WHO, 1998)

Key Informants

Individuals who are knowledgeable about and influential with particular segments of the population. (CDC, 1996)

Lifecycle

Media Advocacy

The strategic use of mass media to advance a social or political policy initiative.

Attempts to reframe community-based public dialogue and to increase support by the public in general and community policy and decision makers in specific for health public policies (Wallack et al, 1993)

Mediation

A process through which the different interests (personal, social, economic) of individuals and *communities*, and different sectors (public and private) are reconciled. (WHO, 1998)

Motivators

Factors that help prompt or sustain knowledge, *attitudes*, or behaviors for a *target audience*. (CDC, 1998)

Needs Assessment

The process of obtaining and analyzing information from a variety of sources to determine the needs of a particular population or *community*; similar to a "marketplace assessment." (CDC, 1996)

Negative Appeal

A *message* that is focused on unpleasant consequences rather than rewards or benefits. (CDC, 1998)

Negotiation

The process of conferring, bargaining, or discussing with the intent of reaching agreement. Also called shared decision making. (Neufeldt, 1991)

Network

A grouping of individuals, organizations and agencies organized on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust. (WHO, 1998)

Opinion Leader

A person within a given social system who is able to influence other individuals' *attitudes* or behaviors with relative frequency (Rogers, 1995).

Outcome

A change in an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change *health status*. (WHO, 1998)

Positive Appeal

A *message* that is focused on benefits or rewards rather than negative consequences. (CDC, 1998)

Psychographics

A set of *variables* that describes an individual in terms of overall approach to life, including personality traits, values, beliefs, preferences, habits, and behaviors. Psychographics are not usually related to health-specific issues, but more commonly to consumer- or purchase-specific behaviors, beliefs, values, etc. (CDC, 1998)

Risk Communication

An interactive process of exchange of information and opinion among individuals, groups and institutions, involving multiple messages about the nature of risk and other messages, not strictly about risk, that express concerns, opinions, or reactions to risk messages or to legal and institutional arrangements for risk management (National Research Council, 1989)

Risk Factor

Social, economic or biological status, behaviors or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury. (WHO, 1998)

Self-efficacy

The belief in one's capabilities to organize and execute the source of action required to manage prospective situations. (Bandura, 1986)

Situational Analysis

A review and analysis of the current environment with regard to the issue at hand, including support for and potential *barriers* to prevention efforts. This information is used in making decisions about *target audiences*, behavioral *objectives*, geographic area to cover, and players to involve. (Adapted from: CDC, 1998)

Social Capital

The degree of social cohesion which exists in *communities*. It refers to the processes between people that establish *networks*, norms, and social trust, and facilitate co-ordination and co-operation for mutual benefit. (WHO, 1998)

Social Environment

The immediate physical surroundings, social relationships, and cultural milieus within which defined groups of people function and interact. Components of the social environment include built infrastructure; industrial and occupational structure; labor markets; social and economic processes; wealth,; social, human and health services; power relations; government; race relations; social inequality; cultural practices; the arts; religious institutions and practices and beliefs about place and community. (NIH, 2000)

Social Marketing

The application of commercial marketing technologies to the analysis, planning, execution, and *evaluation* of programs designed to influence the voluntary behavior of *target audiences* in order to improve their personal welfare and that of their society. Social marketing-driven programs, which incorporate more than *messages*, include components commonly referred to as the "4 Ps"—product, price, place, and promotion. The balance of the 4 Ps is called the marketing mix. (Andreasen, 1994; CDC, 1998)

Social Networks

Social relations and links between individuals which may provide access to or mobilization of *social support* for *health*. (WHO, 1998)

The peers, friends and relatives with whom an individual has close relationships. Social networks provide support—either emotional or material support, services, information and new social contacts—to their members. (UNICEF, 2001)

Social Norms

Perceived standards of behavior or attitude accepted as usual practice by groups of people. (CDC, 1996)

Social Support

That assistance available to individuals and groups from within *communities* which can provide a buffer against adverse life events and *living conditions*, and can provide a positive resource for enhancing the *quality of life.* (WHO, 1998)

Stakeholders

Persons who have an interest and/or investment in a given issue, problem or program. These can include people from the community level, development agents, local officials or government staff. (UNICEF, 2001)

Those who have an interest in and can affect implementation of an intervention or program; key players; influentials. (CDC, 1996)

Stigma (AIDS-related)

Prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV and the individuals, groups and communities with which they are associated. AIDS stigma is effectively universal, but its form varies from one country to another, and the specific groups targeted for AIDS stigma vary considerably. (Herek, 1998)

Surveillance

An ongoing process of information collection, analysis, interpretation, and dissemination to monitor the occurrence of specific health problems in populations. (CDC, 1996)

Sustainable Development

The use of resources, direction of investments, the orientation of technological development, and institutional development in ways which ensure that the current development and use of resources do not compromise the *health* and well-being of future generations. (WHO, 1997a)

Target Audience

The group(s) of individuals to whom the *message* is intended to be conveyed.

Primary audience

The group(s) of individuals whose behavior, *attitudes*, or beliefs the communication is trying to influence.

Secondary audience

A group(s) of individuals that can help reach or influence the intended audience segment, but is not considered part of the problem.

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